Division of Mental Health and Addiction
402 W. WASHINGTON STREET, ROOM W353
INDIANAPOLIS, IN 46204-2739
317-232-7800
FAX: 317-233-3472

"People helping people help themselves"

Community-Based Options for Youth and Families
Intensive Home and Community-Based Wraparound Services

Incident Report Form — Confidential

Please submit completed report form via secure fax (317) 233-1986

SECTION I – CONSUMER INFORMATION (Subject #1)

Slot#: _____ DOB: _____ Gender: M F County: _____

Last Name: _____ First Name: _____

Address: _____

City, State Zip: _____

Primary Funding Source: ☐ PRTF Transition Waiver ☐ MFP-PRTF Demo Grant **(DO NOT COMPLETE THIS FORM—Go to: htts://DDRSprovider.fssa.IN.gov/ifur/default.aspx)**

INDICATE WHICH OF THE FOLLOWING AGENCIES AND INDIVIDUALS HAVE BEEN INFORMED

Check all that apply and provide:

☐ Residential Provider
☐ Legal Guardian
☐ Habilitation/Vocational Provider
☐ Wraparound Facilitator
☐ CPS
☐ Coroner
☐ Police

Name: _____ Date: _____
Name: _____ Date: _____
Name: _____ Date: _____
Name: _____ Date: _____
Name: _____ Date: _____
Name: _____ Date: _____
Name: _____ Date: _____

Supervisory Provider Information:

Responsible Supervisory Provider: _____

Individual Supervising at Time of Incident: _____

SECTION II – REPORTING PERSON AND REPORTING AGENCY

Last Name: _____ First Name: _____ Position: _____

Phone: _____ Email: _____

Date Report Submitted: _____ Reporting Agency: _____

SECTION III – INCIDENT INFORMATION

Incident Type (Brief Description): _____

Date Incident Occurred: _____ Time Incident Started: _____ AM / PM

Where Incident Occurred:

☐ Home, Own ☐ Home, Family ☐ Hospital ☐ PRTF ☐ School ☐ Other (Explain): ☐ Service Location ☐ Community

INCIDENT INITIAL REPORT (STANDARD) — CONFIDENTIAL

As Report in Section I – Consumer Information (Subject #1) – Confidential

Consumer Name: _____ Slot #: _____

Incident Date: _____ Incident Time: _____ AM / PM

NARRATIVE: DETAILS — STANDARD

Describe the injury, condition or circumstance of the incident and the activities taking place immediately prior to the incident. Identify all participants and their involvement in the incident. Please be comprehensive but concise in explaining *who*, *when*, *where*, *why*, *how* and *what* was heard and/or observed:

Plan to Resolve (Immediate and Long-Term):

INCIDENT INITIAL REPORT (DEATH) — CONFIDENTIAL

Is this incident regarding the death of this consumer? ☐ Yes ☐ No

As Report in Section I – Consumer Information (Subject #1)

Consumer Name: _____ Slot #: _____

Incident Date: _____ Incident Time: _____ AM / PM

NARRATIVE: DETAILS — DEATH

1.) Date of Death: _____ Time of Death: _____ AM / PM

2.) Place of Death:

☐ Home, Own (house, apt, etc) ☐ Service Location ☐ PRTF
☐ Home, Other (family, friend, etc) ☐ Hospital ☐ Work
☐ Foster Home ☐ School ☐ Community
☐ Other (Explain):

3.) Circumstances immediately preceding the death, if known:

4.) Circumstances immediately following the death or discovery of the death, if known:

5.) Describe all life-saving measures, IF ANY WERE APPLICABLE, attempted at the time of death (i.e., CPR administered, 911 called, transported to hospital, etc.), if known:

6.) If no life-saving measures were taken, explain why not (i.e., no-code status, do not resuscitate (DNR) order, etc.), if known:

7.) Was the death of the individual expected? ☐ Yes ☐ No

8.) Was there a DNR status? ☐ Yes ☐ No ☐ Unknown

9.) What is the preliminary cause of death?

10.) Description of the event(s) surrounding this death is as follows:

Policy/Procedure Approval		
Revised: April 2013	Incident Report Form for Community Options for Youth and Families Programs	
OMPP Approval:	On file	**Date:** April 2013
DMHA Approval	On file	**Date:** April 2013